Guidance for Implementation
Advance Care Planning
COVID-19

Background

Proactive discussions about patient wishes, advance care planning, end of life care, and shared decision making around associated risks with treatment, is an essential part of routine renal care and more vital in a pandemic situation.

Clinicians should ensure patients receive the care they want, aligning the care that is delivered with the patient's values and goals. The importance of goal concordant care is not new or even substantially different in the context of this pandemic, but it's importance is heightened.

Advance care planning before an acute severe illness related to COVID-19 and discussions about goals should be a high priority for three reasons.

1. Clinicians should strive to avoid intensive, life-sustaining treatments when unwanted by patients.
2. Avoiding non-beneficial or unwanted, high-intensity care becomes especially important in times of stress on healthcare capacity.
3. The provision of non-beneficial or unwanted, high-intensity care may put other patients, family members, and health care workers at higher risk of transmission of COVID-19.

Suggested Implementation Plan

Steps	Suggested Steps	Description	Responsible
1 **Identify Patients**	**Who would most likely benefit from an ACP discussion in a pandemic?** **Patients deemed highest priority receive "Documenting Your Goals of Care" letter- see Appendix 1** **Suggestions for Identifying patients: Surprise Question - Would you be surprised if your patient died in 6-12 months?** **Frailty scale 4 and above:**	**Copies will be made and distributed in HD Unit to identified patients** **Copies available in English, Chinese and Punjabi**	**Shared responsibility**

	https://www.dal.ca/sites/gmr/our-tools/clinical-frailty-scale.html **Clinical Indicators:** • **Multiple vascular access issues** • **Sentinel events (falls, serum albumin, weight loss, poor BP control)** • **Hospitalizations** • **Dependence on others** • **Bed or chair bound** • **Multiple co-morbidities**		
2 **Identify Champion/ ACP Discussion Lead**	**Dialysis unit identifies champions to have discussions with patients**	**Designated champion follows up with patient** **This can be done in person, or by telephone**	**Champion/ACP Lead/Nephrologist/Social Worker or a clinician who has an established relationship with the patient**
3 **Documentation**	**Document Goals of Care in MOST** **Document in the patient medical record- EMR or paper chart** **Document ACP discussions in PROMIS** http://www.bcrenalagency.ca/resource-gallery/Documents/ACP%20notepad.pdf	**An updated MOST will allow the team to access important information in the event of an emergency** **Updating this information in PROMIS will allow reporting to Ministry of Health during pandemic**	**Champion/ACP Lead** **Unit Clerk**

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Suggested Script

Adapted Guide for Serious Illness Conversations with Hospitalized high-risk COVID-19 Patients	
CONVERSATION FLOW	**SUGGESTED LANGUAGE**
1. **SET UP THE CONVERSATION**	"I'd like to talk about what may be ahead for you with this illness and do some planning about what is important to you so that I can make sure we provide you with the best possible care, **is this okay**?"
2. **ASSESS UNDERSTANDING AND PREFERENCES**	"**What is your understanding** of how COVID-19 is affecting people like you? [eg people who are older and/or frail, people with significant comorbidities] **"What information about what is ahead would you like from me**?"
3. **SHARE INFORMATION & PROGNOSIS:** **Allow silence & explore emotion*	*Frame as a **"wish…worry"** or **"hope…worry"** statement EG "COVID - 19 is a viral illness that spreads like the flu. We know it is particularly serious in patients like you. **I wish** we were not in this situation, **but I'm worried** that you could get much sicker very quickly. If that happens you are at risk of dying in a short period of time."
4. **EXPLORE KEY TOPICS:** a. Goals b. Fears c. Sources of strength d. Family e. Notify	"If things get worse, **what would be most important to you**?" "**What are you most afraid** of right now?" "**What gives you strength** as you think about what may be ahead with this illness?" "**How much does your family know** about what's important to you?" "**Is there anyone you would like me to contact**?"
5. **CLOSE THE CONVERSATION**	"**I've heard you say** that ____ is important you right now. Keeping this in mind, and what we know about this illness, I recommend that ___." "**How does this plan seem to you**?" "**We will do everything we can** to help you through this. EG: "I've heard you say that not suffering if you become more short of breath is important to you. Keeping in mind what we know about this illness, and what you've shared with me, I recommend that we admit you to hospital and treat you with oxygen and medicine to help with your shortness of breath. If things worsen, we will not send you to the intensive care unit as that will only prolong your suffering. But we will continue to aggressively treat your symptoms so you remain comfortable. How does this sound?"
6. **DOCUMENT & COMMUNICATE KEY CLINICIANS**	1. **DOCUMENT** in Health Record 2. Ensure the Resuscitation Status order (MOST, POLST, Code Status) 3. Personally inform provider(s) who should know
This material has been modified by Providence Health Care (contacts Wallace Robinson, Dr Rose Hatala, & Dr Lauren Daley at	

Appendix 1

Documenting your Goals of Care - Available in 3 languages

English, Chinese and Punjabi

Documenting your Goals of Care

Effective Date: March 27, 2020

Dear Patient,

In light of the serious outbreak of the COVID-19 virus, we are asking you to reflect on your advance care planning: wishes, goals and fears. We understand you have been faced with many changes over the past days to weeks – thank you for your patience and understanding as we strive to provide the best possible care according to a thoughtful, organized plan developed by your multi-disciplinary team of renal care providers.

Those of you living with chronic kidney disease are potentially more vulnerable to severe complications of COVID-19 infection. This is why it's important for your care wishes to be documented clearly now, should your health status change during this time.

Over the next few weeks we will be approaching you to update your wishes in the Medical Order Scope of Treatment (MOST), which is a plan of care reflecting your treatment and care requests. Having conversations regarding what matters most to you through your illness journey is part of our high standard of care. Specifically, this refers to ensuring your wishes regarding the level and intensity of treatment are expressed, heard, respected and clearly documented.

These are uncertain times, but you can be certain, and reassured, that your renal care team will continue to support you through whatever challenges lie ahead.

Respectfully yours,

Your Renal Care Provider Team

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記錄您的護理目標

生效日期：2020 年 3 月 27 日

敬愛的患者，

鑑於新型冠狀病毒(COVID-19)的疫情嚴重爆發，我們現請您反思您的預設護理(advance care planning)，其中包括：您的意願，目標以及讓您擔憂的事項。我們了解在過去幾天甚至於幾週內，您正面臨到許多變化 – 我們正竭盡所能，根據您的腎臟護理團隊仔細策劃所作出的治療計劃，為你提供最完善的護理。在此衷心感謝您的耐心和體諒。

慢性腎病患者可能更容易因受到新型冠狀病毒（COVID-19）感染而引起嚴重併發症。因此，若能在健康狀況產生變化前，適時明確地記錄您的護理意願尤其重要。

在接下來的幾週內，我們將與您聯絡以更新您在治療範圍醫囑（Medical Order for Scope of Treatment (MOST)）中的意願，這是一項能夠反映您在治療和醫療護理方面所要求的計劃。 就您在治療過程中最重要的事宜進行對話是我們維持高水準護理的一部分。 具體來說，這是為確保您在治療範圍及其使用程度的意願得以被尊重及明確地表達、聆聽和記錄下來。

雖然現時仍然存在許多不明確的因素，但您可以放心。您的腎臟護理團隊將繼續協助您應對可能會面臨的任何挑戰。

您的腎臟護理團隊
謹啟

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ਅਪਣੇ ਇਲਾਜ ਦੇ ਨਿਸ਼ਾਨਿਆਂ ਦਾ ਰਿਕਾਰਡ

ਮਾਰਚ 27,2020 ਤੋਂ ਲਾਗੂ

ਪਿਆਰੇ ਮਰੀਜ਼,

ਕੋਵਿਡ -19 ਵਾਇਰਸ ਦੇ ਗੰਭੀਰ ਫੈਲਾਓ ਦੀ ਰੋਸ਼ਨੀ ਵਿਚ ਅਸੀਂ ਤੁਹਾਨੂੰ ਅਪਣੇ ਇਲਾਜ ਦੇ ਬਾਰੇ ਅਗਾਊਂ ਸੋਚ ਵਿਚਾਰ ਕਰਨ ਬਾਰੇ ਕਹਿ ਰਹੇ ਹਾਂ:ਇੱਛਾਵਾਂ, ਨਿਸ਼ਾਨੇ ਅਤੇ ਫਿਕਰ. ਅਸੀਂ ਸਮਝਦੇ ਹਾਂ ਕਿ ਪਿਛਲੇ ਦਿਨਾਂ ਤੇ ਹਫਤਿਆਂ ਵਿਚ ਤੁਹਾਨੂੰ ਕਈ ਤਬਦੀਲੀਆਂ ਦਾ ਸਾਹਮਣਾ ਕਰਨਾ ਪਿਆ ਹੈ- ਤੁਹਾਡੇ ਸਬਰ ਤੇ ਸਮਝਣ ਦਾ ਧੰਨਵਾਦ ਕਰਦੇ ਹਾਂ, ਜਦੋਂ ਕਿ ਅਸੀਂ ਇਕ ਸੋਚੀ ਸਮਝੀ ਵਿਓਂਤ ਅਨੁਸਾਰ ਤੁਹਾਡੇ ਗੁਰਦੇ ਦੀ ਹੋਰ ਮਾਹਿਰਾਂ ਦੀ ਸਾਂਭ ਸੰਭਾਲ ਟੀਮ ਮੁਤਾਬਕ ਸਭ ਤੋਂ ਵਧੀਆ ਇਲਾਜ ਦੇਣ ਦੀ ਕੋਸ਼ਿਸ਼ ਕਰ ਰਹੇ ਹਾਂ।

ਤੁਹਾਡੇ ਵਿਚੋਂ ਗੁਰਦੇ ਦੀ ਪੁਰਾਣੀ ਬੀਮਾਰੀ ਵਾਲੇ ਮਰੀਜ਼ਾਂ ਤੇ ਕੋਵਿਡ-19 ਇਨਫੈਕਸ਼ਨ ਦੀਆਂ ਗੰਭੀਰ ਉਲਝਣਾਂ ਦਾ ਜ਼ਿਆਦਾ ਅਸਰ ਹੋ ਸਕਦਾ ਹੈ।ਇਸ ਲਈ ਇਹ ਜ਼ਰੂਰੀ ਹੈ ਕਿ ਜੇ ਇਸ ਸਮੇਂ ਦੌਰਾਨ ਤੁਹਾਡੀ ਸਿਹਤ ਦੀ ਸਥਿਤੀ ਬਦਲਦੀ ਹੈ ਤਾਂ ਤੁਸੀਂ ਅਪਣੀ ਸਾਂਭ ਸੰਭਾਲ ਦੀਆਂ ਇੱਛਾਵਾਂ ਨੂੰ ਹੁਣ ਹੀ ਸਪਸ਼ਟ ਕਰ ਦਿਓ।

ਅਗਲੇ ਕੁਝ ਹਫਤਿਆਂ ਦੌਰਾਨ ਅਸੀਂ ਤੁਹਾਨੂੰ ਪਹੁੰਚ ਕਰਾਂਗੇ ਕਿ ਤੁਸੀਂ ਮੈਡੀਕਲ ਆਰਡਰ ਸਕੋਪ ਆਫ ਟਰੀਟਮੈਂਟ (ਐਮ ਓ ਐਸ ਟੀ) , ਜੋ ਇਕ ਪਲੈਨ ਹੈ ਜਿਸ ਵਿਚ ਤੁਹਾਡੀ ਸਾਂਭ ਸੰਭਾਲ ਤੇ ਇਲਾਜ ਦੀਆਂ ਇਛਾਵਾਂ ਦਰਜ ਹੁੰਦੀਆਂ ਹਨ, ਨੂੰ ਅਪਡੇਟ ਕਰ ਦਿਓ।ਤੁਹਾਡੀ ਬੀਮਾਰੀ ਦੌਰਾਨ ਤੁਹਾਡੇ ਵਾਸਤੇ ਅਹਿਮ ਕੀ ਹੈ , ਇਸ ਬਾਰੇ ਗਲਬਾਤ ਕਰਨਾ, ਇਹ ਸਾਡੀ ਵਧੀਆ ਸਾਂਭ ਸੰਭਾਲ ਦਾ ਹਿੱਸਾ ਹੈ। ਵਿਸ਼ੇਸ ਤੌਰ ਤੇ ਇਸ ਵਿਚ ਤੁਹਾਡੀਆਂ ਸਾਭ ਸੰਭਾਂਲ ਤੇ ਇਲਾਜ ਦੇ ਪੱਧਰ ਦੀਆਂ ਇਛਾਵਾਂ ਦਰਜ ਹੁੰਦੀਆਂ ਹਨ, ਜੋ ਧਿਆਨ ਨਾਲ ਸੁਣੀਆਂ, ਸਤਿਕਾਰੀਆਂ ਤੇ ਰਿਕਾਰਡ ਕੀਤੀਆਂ ਜਾਂਦੀਆਂ ਹਨ।

ਇਹ ਬੇਯਕੀਨੀ ਵਾਲਾ ਸਮਾਂ ਹੈ , ਪਰ ਤੁਸੀਂ ਯਕੀਨ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਭਰੋਸਾ ਰੱਖੋ ਕਿ ਜੋ ਵੀ ਚੁਣੌਤੀਆਂ ਅੱਗੇ ਆਓਣਗੀਆਂ, ਤੁਹਾਡੇ ਗੁਰਦੇ ਦੀ ਸਾਂਭ ਸੰਭਾਲ ਟੀਮ ਤੁਹਾਡੀ ਮਦਦ ਜਾਰੀ ਰੱਖੇਗੀ।

ਸਤਿਕਾਰ ਸਹਿਤ,
ਤੁਹਾਡੀ ਗੁਰਦੇ ਦੀ ਸਾਂਭ ਸੰਭਾਲ ਟੀਮ